New Day Psychological Services LLC

AUTISM AND INTELLECTUAL DISABILITY ASSESSMENT SERVICES

AUTISM | Intellectual Disabilities

CONFIDENTIAL REPORT
THIS REPORT MAY NOT BE RELEASED TO ANY OTHER PARTY WITHOUT THE CONSENT OF THE EVALUATED OR RESPONSIBLE PARTY

CONSENT FOR TREATMENT

Children and Adolescents (Ages 17 and under)

Purpose:

The purpose of this policy is for the responsible party/parties of a child or adolescent to provide their written consent for their child/adolescent to be provided with mental health treatment at New Day Psychological Services LLC.

Definition of Consent:

For the purpose of this policy *Consent* refers to the responsible party/parties giving permission for mental health treatment to be provided to their child/adolescent. The specific type of treatment to be provided will be specified below.

Definition of Child/Adolescent:

For the purpose of this policy, *Child/Adolescent* refers to any individual under the age of 18 years old. While state laws permit persons of the age of 14 years old to provide consent for their own mental health treatment, it is the policy of New Day Psychological Services LLC to obtain consent from the responsible party/parties for all persons under the age of 18. This is fully explained in the Informed Consent Policy which will be reviewed in conjunction with this document.

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NewDayPsychological@gmail.com

Limits of Consent:

A responsible party has the right to withdraw consent for the treatment of his/her child or adolescent at any time. This may be completed verbally or in writing. In cases where there is more than one responsible party, the withdrawal of one party will result in the cessation of services.

If a responsible party decides to withdraw consent the possible impact this could have on the child/adolescent will be reviewed at that time. If referral to another treatment professional is desired at that time, the clinical/administrative staff at New Day Psychological Services will assist with this process.

Except in cases where full custody has been assigned to one parent, or to another party, the signature of both parents will be required on this policy prior to any services being provided to any individual under the age of 18.

In cases where custody has been assigned by the courts, a copy of the document provided by courts granting the custody order must be provided prior to any services being provided to any individual under the age of 18.

Clinician Credentials:

Treatment will be provided by the following clinician who possesses the noted credentials. You have the right to refuse treatment provided by this individual in lieu of the treatment being provided by another clinician in this practice, or a clinician in an alternative practice.

__X___ Robert B. Carey Psy.D. – Licensed Clinical Psychologist
_____ Jennifer Mansfield M.S. – Psychological Associate

As per regulations of the Department of Public Welfare (DPW), treatment notes/evaluations for all clients insured by Medical Assistance/CBHNP will be read and approved by Dr. Carey regardless of the clinician who completes the treatment.

Declaration of Consent:

My signature indicates my consent to _____ being provided with the following mental health treatment at New Day Psychological Services LLC:

_____Psychotherapy
__X___Psychological Evaluation
_____Psychological Testing
___X___Intelligence Testing
_____Achievement Testing
__X____Adaptive Testing
_____Personality Testing
_____Other: Specify: _____

My signature also acknowledges that I have had the information in this document as well as the Informed Consent policy reviewed with me and that I have had the opportunity to ask questions that I have regarding these policies.

_____ _____ _____
Signature of Responsible Party Relationship Date

Printed Name: _____

_____ _____ _____
Signature of Responsible Party Relationship Date

Printed Name: _____

Refusal of Consent: **_____Not Applicable**

After reviewing this document as well as the Informed Consent document I do not provide consent for _____ to be provided with mental health services at New Day Psychological Services LLC at this time.

_____ _____ _____
Signature of Responsible Party Relationship Date

Printed Name: _____

_____ _____ _____
Signature of Responsible Party Relationship Date

Printed Name: _____

Withdrawal of Consent:

As of date _____ I withdraw my consent for _____ to be provided with further mental health treatment at New Day Psychological Services LLC.

_____ _____ _____
Signature of Responsible Party Relationship Date

Printed Name: _____

_____ _____ _____
Signature of Responsible Party Relationship Date

Printed Name: _____

_____Withdrawal of Consent received via phone call
Date/Time of Call: _____
Call Received By: _____

Referrals/Other Actions Taken by Clinical Staff:
_____
_____
_____
_____
_____
_____
_____